REPUBLIC OF GHANA

What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

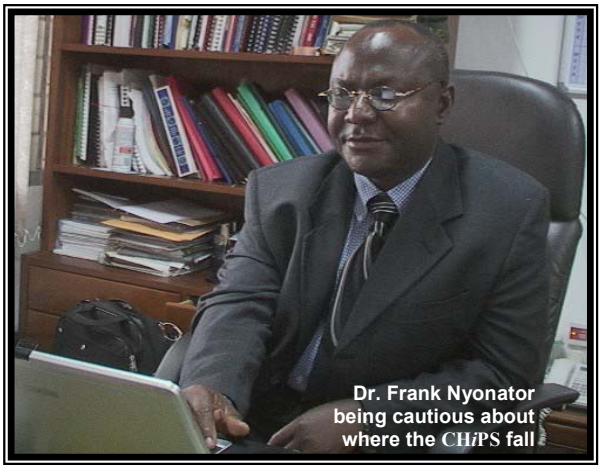
Vol. 4, No. 16 Navrongo Health Research Centre

FRANKLY SPEAKING…

Dr. Frank Nyonator is Director of the Polic,y Planning, Monitoring and Evaluation Division (PPME) of the Ghana Health Service. He has direct responsibility for coordinating the implementation of the Community-based Health Planning and Services (CHPS) Initiative, a nationwide health care delivery initiative based on findings from the Navrongo Community Health and Family Planning Project. He never speaks to say nothing. Hear him in "What works..." notes 16 and 17.

You were the first Regional Director of Health Services to replicate the Navrongo Community Health and Family Planning project. What motivated you to do this?

I had visited Navrongo with a couple of others, basically to look at avenues for holding in-service training for district directors. When we arrived in Navrongo and saw what the Community Health and Family Planning Project (CHFP) was doing, we immediately decided that this was a place we would like to train district directors. We also realised the project was an efficient way of extending services to the poor and could be replicated in other parts of the country. When we got back we began to put together a programme. At that time Dr. Moses Adibo (then Deputy Minister of Health) too had begun to disseminate results of the CHFP. It then dawned on me that the programme in Navrongo had good prospects for increasing coverage of health services. So I went back to Navrongo to take a more critical look at the CHFP service delivery strategy. When I returned to the region I mobilized all the district directors, put them in a bus and drove them to Navrongo. I challenged them to look at the CHFP as a workable strategy for achieving the kind of service coverage that they had yearned for but had never achieved. That is how the Volta region took the lead in scaling up the Navrongo service delivery model.



Dr. Frank Nyonator being cautious about where the CHPS fall

What factors accounted for the successful replication of Navrongo in the Volta Region?

Much of it depended on regional enthusiasm and leadership at the district level. Leadership takes up to about 80% of what is required to make an innovation work in a different setting. When the district directors returned from Navrongo, I urged them to write proposals on how they could utilize the ideas they had learned. About four or five district directors responded. So right from the word go the leaders distinguished themselves. Nkwanta became very enthusiastic. South Tongu and North Tongu also showed keen interest. I encouraged them to start on their own using resources at their disposal. At the regional level we also started writing proposals on how to translate the Navrongo research findings into actual service delivery. We eventually got Africare to support the region and sponsor three districts to replicate Navrongo. Africare wanted to monitor closely what they were doing but felt Nkwanta was too far from Accra so they chose to work with South Tongu and North Tongu. Nkwanta was left to struggle on their own. The Navrongo experiment was not a blue print of how things should be done. It's a trial-and-error method. When the district directors returned from Navrongo the District Director of Nkwanta went back about five more times. He kept at it till he got it right.

What were some of the difficulties encountered?

We had two scenarios—the Nkwanta one which proceeded solely on district-based resources and the South Tongu and Akatsi districts which had some project support. There were also administrative bottlenecks. For instance, how motorbikes and incentives were to be provided for the nurses going to live in the communities was not immediately known. Nkwanta came out with its programme and the regional directorate supported them. Some districts felt constrained by the absence of clear guidelines for dealing with the new concept. The regional office had to give them some backing and urged them to use part of their internally generated funds. The other challenge was how to deal with the project-supported districts. We had our own arrangements and the funding agency had their own as well. How to

balance the two seemingly divergent interests though aiming at the same goal was a complicated issue. There were a lot of tradeoffs but we eventually came to some understanding. With Nkwanta, we provided only administrative coverage for them to move but in the other districts there was a lot of negotiation. We then began to develop proposals as to how to monitor the work that was going on. We sold our idea to the other regional directors about the need to put in place some monitoring mechanism. They agreed that the Volta region should blaze the trail in this exercise. We haven't seriously thought of these as difficulties because it has all been a learning process.

What is your idea of non-negotiable steps in the CHPS implementation process?

We must recognize and accept that CHPS is a community-based health care delivery programme. That is why we started by building capacity for community mobilisation. Through the District Health Systems Operations workshop, an in-service training programme for district health workers, we had Navrongo prepare a module on community mobilisation which every district that participated in the training had to go through. So it came to me as a big surprise that most of the districts that were reporting to the PPME were not engaging the communities in the process. CHPS is a process whereby the communities determine what services they want and how they want them provided. So it is important to get the communities first of all to be aware of what the possibilities for delivering health services are and to accept to spearhead the process of decentralizing access to their doorstep; to assist the Community Health Officer (CHO) to relocate to their community and provide services. If this process of sensitising and engaging the communities has not been followed through, frankly speaking, you are not implementing CHPS. The non-negotiable steps include the District Health Management Team (DHMT) analysing its situation and determining what areas are poorly covered and how the CHPS strategy can bring improvement. The second step is for the DHMT to build consensus among its members. Then dialogue ensues with community members in the selected zone. When this is properly done, issues pertaining to getting a dwelling place for the incoming CHO becomes easy to arrange because the community has to contribute resources no matter how small. Next, the community identifies volunteers to assist the CHO in her work as well as agreeing on how to compensate the volunteers' efforts. Payment of the volunteers by the health bureaucracy has not worked in the past and the system was not going to walk that path again.

The road to CHPS is more popular than the alternative

Why do you think some are proceeding with CHPS implementation this way? Did you foresee this happen?

What we have realised from the M&E results is that some districts have missed the concept—they just write letters posting nurses to communities and asking them to go to their duty post. A good number of districts complain that their biggest obstacle is how to get Community Health Compounds (CHC). This creates the erroneous impression that CHPS is CHC dependent. But now it is clear that the issue arises as a result of failure to engage the communities to make a contribution. We studiously broke down the implementation into steps—some 15, others 24—grouped into six milestones. These are meant to be a guide—the steps were not cast in steel to be followed in a certain order. CHPS is a process of learning by doing and we amply made this clear. The steps can be followed in a certain pattern depending on the situation. We knew there would be a lot of innovation in the process of implementing the new concept but the managers on the ground just had their style. It has all been a learning process and as we proceed we get a clearer and clearer sense of direction.

What is your strategy for engaging development partners?

We have tried to get donors to identify with and support the development of manuals for training of CHO, provision of logistics such as motorbikes (which is capital intensive), communication systems, and assistance with monitoring and evaluation. We have tried to discourage development partners going directly to districts and trying to carve out what support they like to offer. We need to standardize and synchronize the way CHPS is implemented—and donor support is best coordinated from the national level.

Send questions or comments to: What works? What fails?
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This series has been launched to share experiences with people in Ghana and elsewhere around the world about what has worked and what has failed in an experiment to make primary health care widely accessible to rural people. The Kassena-Nankana community, whose active participation made *The Navrongo Experiment* possible, are hereby duly acknowledged. This publication was made possible through support provided by the Office of Population, Bureau for Global Programmes, Field Support & Research, U.S. Agency for International Development, under the terms of Award No. HRN-A-00-99-00010. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development. Additional support was provided by a grant to the Population Council from the Bill and Melinda Gates Foundation. The Community Health Compound component of the CHFP has been supported, in part, by a grant of the Vanderbilt Family to the Population Council.